CATASTROPHIC LEAVE SHARING PROGRAM

Physician Certification Statement

1. Employee Name: _____

2. Patient Name: _____

For certification relating to the employee's serious health condition, please answer questions 3 – 4 below:

3. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussing with the employee).

Yes: _____ No: _____

4. Date condition began: _____Probable ending: _____

For certification relating to the care of the employee's seriously ill family member, please answer questions 5 – 7 below:

5. Is inpatient hospitalization of the family member (patient) required?

Yes: _____ No: _____

6. Will the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation?

Yes: _____ No: _____

7. Date assistance of employee to begin: _____

8. Probable ending date of employee assistance: _____

Signature of Physician/Practitioner: _____

Print Physician Name: _____

Full Address: _____

Telephone Number: _____

Date: _____

Return to Catastrophic Leave Program Coordinator Elaine Andrews at L707 or fax to ext. 22401